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Dear Colleagues:

Deciding where to send your patients who need comprehensive geriatric care can be difficult. Our goal in Cleveland Clinic’s Center for Geriatric Medicine is to serve as a central resource for geriatric and gerontological clinical, educational and research activity throughout the region. The center coordinates programs, and advises and assists clinicians through a system of nine hospitals and 16 family health centers. We are eager to assist and educate physicians, nurses, therapists, social workers, other clinical health providers and caregivers in improving the care of the oldest and most frail members of society.

This year has been one of tremendous growth for the center. Dr. Amanda Lathia, one of our junior faculty, has received a Geriatric Academic Career Award, a very competitive award through the Health Resources and Services Administration to further geriatric education. We opened our new Geriatrics Center on the main campus and patients and families have applauded the improved accessibility. Our outstanding team of experts in geriatric care collaborate across our system to coordinate the best care for older adults.

We are proud to be named in the nation’s top 10 for geriatric care in U.S. News & World Report.

In this issue, we describe our new space; outline our approach to geriatric cancer care; share insights into stroke, spinal stenosis and fecal incontinence in the elderly; and offer guidelines for assessing abuse. These articles represent a small sample of the work we do every day to help make a real difference in the quality of our patients’ lives.

We look forward to continuing our partnership with you. Please don’t hesitate to contact me with any questions, concerns or suggestions on how we might improve our services to you and your patients in the future at 216.444.5665, or email rapporb@ccf.org.

Kind regards,

Barbara Messinger-Rapport, MD, PhD
Director, Center for Geriatric Medicine
Medicine Institute
Geriatric Fellowship Teaches More than Medicine

Geriatrics is not the most glamorous of specialties. “It’s not for everyone,” admits Jerry Ciocon, MD, FACP, FACA, AGSF, Department Chair of the Center for Geriatric Medicine at Cleveland Clinic Florida. “It’s harder work than many other specialties, and it’s sometimes hard to deal with older people. Most doctors want to do more high-tech medicine, such as cardiology or pulmonary medicine, where reimbursement is better as well.”

At a time when they are needed the most, there is a lack of physicians who specialize in geriatric care, says Dr. Ciocon. He cites several reasons:
- The rapidly aging U.S. population is outpacing the number of physicians who specialize in geriatric care.
- There are fewer medical school enrollees.
- Geriatric residency programs are not able to fill their complement of slots. Additionally, programs are being forced to eliminate some slots because Medicare has reduced its reimbursement.

In 2002, Cleveland Clinic Florida decided it was time to offer physicians an opportunity to see why geriatrics is such an important specialty by creating a one-year fellowship in geriatric medicine. It is one of only a handful of such programs nationwide. The objective is to teach physicians how to take care of — and interact with — elderly patients and their families. The patients might be well, frail or at the end of life.

Training is comprised of several areas — didactic sessions, clinical rotations, research and quality improvement.

A core lecture is given once a week on common issues related to aging, including physiology; pathophysiology of common geriatric syndromes, such as urinary incontinence, falls, dementia and decubiti ulcers; interaction of diseases; and psychosocial issues.

The fellow does clinical rotations in a number of settings, including outpatient, inpatient hospital, rehabilitation unit, hospice care and long-term care skilled nursing home facility. In all of these settings, they learn how to evaluate the older person in the context of his/her psychosocial setting. They learn to discuss sensitive issues with patients and their families, including whether to stop treatment. In the nursing home environment, the fellow is exposed to patients with dementia and behavior problems, and learns how to discuss it with caregivers and family members. The fellow also learns how to support caregivers. Practice in quality improvement of processes in nursing homes and hospitals, such as transitions of care, is part of the training as well.

“The goal is to show fellows how to talk about and deal with these issues,” Dr. Ciocon says. “They have to learn whether they can handle this themselves. These are issues that most family practitioners and internists don’t feel comfortable with.”

There also is a research component required by the fellowship. Fellows have completed research showing the relationship between low vitamin D and dementia. Currently, research is ongoing looking at the outcome of hip and knee replacements, the effect of meditation on cognitive function of older patients with dementia, how to minimize multiple drug use in nursing home settings, barriers in end-of-life care, and functional outcome of hip fractures in older adults. Clinical journals also are reviewed for the latest accepted techniques and treatments for elderly patients.

Dr. Ciocon emphasizes that training more doctors in geriatric medicine will lead to better care and improved patient satisfaction. He notes that treatment by a geriatrician, rather than an internal medicine physician, can lead to a shorter length-of-stay in the hospital.

“Geriatricians assess the contributions of polypharmacy, psychosocial problems and functional impairments that contribute to the condition and the hospitalization, ” he points out. “Geriatricians are trained to be more patient with elderly patients. The specialty is more holistic.”

Dr. Ciocon believes Cleveland Clinic’s geriatric training program has made a substantial impact in elderly care.

“Our fellows have passed the boards, and most are working in geriatric-related specialties,” he says.

To learn more about Cleveland Clinic Florida’s Geriatric Training Program or to refer a candidate, contact Dr. Ciocon at 954.659.5353 or by email at cioconj@ccf.org.
Cleveland Clinic now offers five Primary Stroke Centers throughout Northeast Ohio to give your patients consistent, high-quality stroke care and treatment. Physicians from Ohio’s highest rated Neurology and Neurosurgery Program are available at Cleveland Clinic main campus, as well as Euclid, Hillcrest, Lakewood and Marymount hospitals.

Cleveland Clinic’s Primary Stroke Center designation demonstrates that its stroke care protocol complies with national standards and guidelines that can significantly improve outcomes for patients.

Cleveland Clinic is a 2010 recipient of the American Heart Association/American Stroke Association’s Get With The Guidelines® (GWTG) — Stroke Gold Plus Performance Achievement Award. This award testifies to our commitment and success in implementing a higher standard of stroke care by ensuring that stroke patients receive treatment according to evidence-based guidelines.

Cleveland Clinic exceeds the target of 85 percent with all seven GWTG — Stroke measures and uses GWTG — Stroke to track comprehensive efforts to rapidly diagnose and treat stroke patients admitted to the Emergency Department. These efforts include being equipped to provide brain imaging scans, having neurologists available to conduct patient evaluation and using clot-busting medications when indicated.

Cleveland Clinic’s care of stroke patients goes beyond immediate intervention, focusing on coordinated care that includes extensive rehabilitation. “Stroke can have devastating effects on a patient’s physical and emotional well-being,” says Irene Katzan, MD, a vascular neurologist at the Cleveland Clinic Cerebrovascular Center, and Director of Enterprise Stroke Systems, Center for Outcomes Research and Evaluation. “We encourage patients to participate in a rehabilitation program that includes physical therapy, occupational therapy, speech therapy and social work, with a physiatrist or other rehabilitation-medicine specialist leading the care.

“The time to work hard is in the early phases right after a stroke,” Dr. Katzan says. “A lot of people just want to go home to their own beds, and many are reluctant to go to rehab and be away from their routine and their family for a few weeks. But if patients use that time effectively and really work in therapy, it’s tremendously beneficial.”

Rehabilitation may involve psychological counseling, since an estimated 25-30 percent of stroke patients suffer from depression. “When people are depressed, they’re not going to participate in rehab as aggressively, and participating in rehab is so critical to optimizing overall functional outcomes,” Dr. Katzan says.

The risk of a recurrent stroke generally is greatest within the first 30 days after the initial stroke. So, Dr. Katzan and colleagues at Cleveland Clinic require their stroke patients to return within 30 days of their discharge.

Photo (left to right): Ruth Yodice, PT, Euclid Hospital Rehabilitation Program; Peter McDonald; Pam Ungar, COTA, Euclid Hospital Rehabilitation Program; Linda McDonald

Tire sleuth tracks down his own road to recovery

Peter McDonald is a forensic specialist, a crime-solver who can identify a tire by its imprint on the road. He’s taught his methods to the FBI and the Royal Canadian Mounted Police. But his life took a bad turn when he suffered a stroke, then righted itself through the efforts of Cleveland Clinic’s rehabilitation team at Euclid Hospital.

“I owe so much to so many people, including my doctors, physical therapists, occupational therapists and many others, especially my caring and supportive wife, Linda,” he says.

He credited Cleveland Clinic with developing an individualized approach to his recovery. It included the best of rehabilitative care combined with personal goal-setting to achieve dramatic results.

Today, Peter has regained an active life. He walks aided only by a cane, goes to a gym regularly, has been recertified to drive and is back to work. His resilience and the efforts of his Cleveland Clinic team are a source of pride to Peter and his wife and shows that this is one tire expert who’s, well, tireless.

Photo (left to right): Ruth Yodice, PT, Euclid Hospital Rehabilitation Program; Peter McDonald; Pam Ungar, COTA, Euclid Hospital Rehabilitation Program; Linda McDonald

Primary Stroke Center Designation Ensures Best Outcome
from the hospital to meet with a member of the stroke care team.

“It’s also important to have patients follow up with their primary care physician knows, and to reconcile any medications.”

Dr. Katzen cites the Aug. 9 online issue of Archives of Neurology, which reported that one-quarter of patients said they had stopped taking at least one of their prescribed stroke-prevention medications within the first three months after being hospitalized. “Our program is designed to decrease non-compliance to improve recovery and reduce the risk of another stroke.”

To refer a patient to the Cerebrovascular Center, please call 216.636.5860 or toll-free 866.588.2264. To arrange a transfer for acute stroke, call Critical Care Transport at 877.379.CODE (2633).

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Measure Description</th>
<th>GWTG Stroke Performance Award Goal</th>
<th>National Average*</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV rt-PA 2 Hour</td>
<td>Acute stroke patients who arrive at the hospital within 120 minutes (2 hours) of time last known well and for whom IV rt-PA was initiated at this hospital within 180 minutes (3 hours) of time last known well.</td>
<td>85.0%</td>
<td>72.8%</td>
<td>66.7% (4/6)</td>
<td>88.9% (8/9)</td>
<td>78.6% (11/14)</td>
</tr>
<tr>
<td>Early Antithrombotics</td>
<td>Patients with ischemic stroke or TIA who receive antithrombotic therapy by the end of hospital day 2.</td>
<td>85.0%</td>
<td>97.0%</td>
<td>97.7% (173/177)</td>
<td>95.3% (261/274)</td>
<td>97.5% (392/402)</td>
</tr>
<tr>
<td>Antithrombotics at Discharge</td>
<td>Patients with ischemic stroke or TIA prescribed antithrombotic therapy at discharge (e.g., warfarin, aspirin, other antiplatelet drug).</td>
<td>85.0%</td>
<td>98.9%</td>
<td>98.6% (352/357)</td>
<td>99.7% (346/347)</td>
<td>99.3% (534/538)</td>
</tr>
<tr>
<td>Anticoagulation for Atrial Fibrillation/ Atrial Flutter</td>
<td>Patients with ischemic stroke, TIA or a hemorrhagic stroke and who are non-ambulatory who receive DVT prophylaxis by end of hospital day 2.</td>
<td>85.0%</td>
<td>98.2%</td>
<td>97.2% (35/36)</td>
<td>98.4% (62/63)</td>
<td>98.7% (78/79)</td>
</tr>
<tr>
<td>DVT Prophylaxis</td>
<td>Patients with ischemic stroke, TIA or a hemorrhagic stroke who are non-ambulatory who receive DVT prophylaxis by end of hospital day 2.</td>
<td>85.0%</td>
<td>98.3%</td>
<td>83.2% (228/274)</td>
<td>88.1% (230/261)</td>
<td>97.2% (350/360)</td>
</tr>
<tr>
<td>Lipids Measure (Statin at Discharge)</td>
<td>Ischemic stroke or TIA patients with LDL &gt; 100, or LDL not measured, or on cholesterol-reducer prior to admission, discharged on cholesterol-reducing drugs.</td>
<td>85.0%</td>
<td>88.3%</td>
<td>83.2% (228/274)</td>
<td>88.1% (230/261)</td>
<td>97.2% (350/360)</td>
</tr>
<tr>
<td>Smoking Cessation Counseling</td>
<td>Patients with ischemic, TIA or hemorrhagic stroke with a history of smoking cigarettes, who are, or whose caregivers are, given smoking cessation counseling during hospital stay.</td>
<td>85.0%</td>
<td>93.6%</td>
<td>100% (101/101)</td>
<td>92.4% (109/118)</td>
<td>92.9% (234/252)</td>
</tr>
<tr>
<td>Dysphagia Screening</td>
<td>Patients with ischemic or hemorrhagic stroke who undergo screen for dysphagia with an evidence-based bedside testing protocol approved by the hospital before being given any food, fluids, or medications by mouth.</td>
<td>85.0%</td>
<td>--</td>
<td>--</td>
<td>67.9% (256/377)</td>
<td>73.7% (490/665)</td>
</tr>
<tr>
<td>Stroke Education</td>
<td>Patients with ischemic, TIA or hemorrhagic stroke or their caregivers who were given education and/or educational materials during the hospital stay.</td>
<td>85.0%</td>
<td>--</td>
<td>--</td>
<td>41.4% (164/396)</td>
<td>80.6% (286/355)</td>
</tr>
<tr>
<td>Rehabilitation Considered</td>
<td>Patients with ischemic or hemorrhagic stroke who were assessed for rehabilitation services.</td>
<td>85.0%</td>
<td>--</td>
<td>83.3% (30/36)</td>
<td>98.5% (393/399)</td>
<td>96.5% (684/709)</td>
</tr>
</tbody>
</table>

New Program Strives to Improve Treatment of Elderly

The Taussig Oncology Program for Seniors (TOPS) in Cleveland Clinic’s Taussig Cancer Institute addresses the unique needs of patients 75 years of age and older who are diagnosed with cancer. The program, launched in July 2009, has a dual goal of improving clinical care for, and conducting research specific to elderly patients undergoing chemotherapy for solid tumors.

Every patient in the geriatric oncology program undergoes a medical and functional assessment at the first visit that becomes a part of the patient’s electronic medical record. This comprehensive assessment for geriatric syndrome includes evaluation for polypharmacy, nutritional status, fall risk, mental status and multiple medical problems.
TOPS answers the need for the specialized treatment approach these patients require to achieve the best possible outcomes, says oncologist Dale Shepard, MD, PhD. He co-directs the geriatric oncology program with oncologist Abdo Haddad, MD.

In addition to board certification in oncology, Dr. Shepard holds PhD in pharmacology. He specializes in gastrointestinal and genitourinary tumors. Dr. Haddad, who is board-certified in medical oncology, geriatrics and palliative medicine, specializes in lung and breast tumors. They form the core of a multidisciplinary team that includes palliative medicine specialists, geriatric social workers, pharmacists, physical therapists, nutritionists, radiation oncologists and bioethicists.

Every patient in the geriatric oncology program undergoes a medical and functional assessment at the first visit that becomes a part of the patient’s electronic medical record. This comprehensive assessment for geriatric syndrome includes evaluation for polypharmacy, nutritional status, fall risk, mental status and multiple medical problems. The results of this assessment form the basis for referrals within the team and to other Cleveland Clinic specialists, and are essential to individualized treatment planning for that patient.

Integrating a comprehensive geriatric assessment like this into cancer treatment for the elderly is a new approach practiced at only a handful of cancer centers nationwide, says Dr. Haddad. He believes a pre-treatment assessment is essential to effectively treating this population.

“There tends to be a fear of chemotoxicity in treating this population simply based on age that can lead to arbitrary chemotherapy dose reduction and potentially less than optimal results” he says. “Age is not a strong predictor of treatment success, and age alone should not be the criteria for chemotherapy dose reduction.”

The paucity of data about chemotherapy dosing in the elderly has motivated Drs. Shepard and Haddad to contribute to the body of knowledge in the field. Defining dosing based on age, functional status and co-morbidities has become a primary focus of TOPS research. To this end, all patients are entered into a registry that captures liver, kidney and cardiac function data prior to, during and after therapy; tumor response; and adverse drug effects. The registry eventually will provide a rich source of data for clinical trials.

Although toxicities or adverse effects occasionally may require dose reduction when treating elderly patients, Drs. Shepard and Haddad prefer to optimize the patient’s condition prior to starting treatment and then to initiate full-dose chemotherapy whenever possible in their patients. “Many patients will benefit from starting with full-dose therapy,” Dr. Shepard explains.

“Our team has the support and resources to resolve any problems that may result and adjust the dose if necessary,” he adds. “Every patient is treated with curative intent and the goal of prolonging survival.”

In addition to comprehensive cancer care, TOPS also offers functional assessment and consultation services to referring physicians for patients over 75 years of age with gastrointestinal, genitourinary, lung and breast tumors.

To refer patients to TOPS, call 216.444.7923 or 866.223.8100.
Diligence Required in Spotting Elder Abuse

Elder abuse is a sad reality for approximately 700,000 to 3.5 million elders in the United States annually and is projected to grow as the population grays in the coming decades. By 2020, the percentage of people over age 65 is projected to increase from 12.5 (in 2000) to 18 percent of the population in 2030 and to 25 percent by 2050.

The National Academy of Sciences defines elder abuse as follows:

- Intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trusted relationship to the elder;

- Failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm.

Elder abuse includes seven categories: physical, emotional/psychological, exploitation/financial, sexual, neglect, self-neglect and abandonment. Ami M. Hall, DO, FP/Geriatrics, Medical Director of the Euclid Geriatric Assessment Program and staff physician at Cleveland Clinic Willoughby Hills Family Health Center, says the most common types of abuse are neglect, particularly self-neglect, and emotional and financial abuse. Current research indicates that more than one in 10 elders may experience some type of abuse, but only one in five cases or fewer are reported. Elder abuse affects seniors across all racial, socioeconomic and religious groups but it is most prevalent among women and persons over 80. The American Medical Association recommends that doctors routinely ask geriatric patients about abuse, even if signs are absent.

It can be hard to distinguish signs of abuse from the normal symptoms of aging. Older adults suffering from abuse, neglect, or financial exploitation may answer questions slowly and/or reluctantly. They may have bruises that they report are from falls or gait instability. They may not fill their medications and claim that they cannot afford them, when in fact the money is being diverted to someone else. They may appear disheveled and unkempt, with urine stains on their clothes. They may be malodorous and malnourished.

“Physicians need more training in recognizing elder abuse, and in utilizing all of their senses during an office visit: vision to identify changes in appearance; active listening to notice reluctance to discuss certain topics; and smell as they lean forward to listen to the patient’s heart or lungs,” says Dr. Hall. “Fortunately, more medical students, residents and interns are doing geriatric rotations and receiving exposure to identifying elder abuse.” All primary
care physicians and certain specialty physicians, especially those who work in the Emergency Department where many elders seek care, need to be able to identify red flags and consider elder abuse when an elder is not receiving the care that he/she needs.

When patients suffer financial exploitation, they may suddenly have difficulty paying bills or purchasing their medications. For elders who are being emotionally abused or controlled by a family member or other caregiver, medical appointments may be the only time they are allowed out of the house. Patients will make “poor eye contact, talk to the ground and not want to answer questions,” says Dr. Hall. Their caregiver will take charge of the situation and speak for the patient. When family members are uncomfortable having healthcare professionals come to the home, it may indicate an abusive situation. The signs of physical abuse are most noticeable: cuts, bruises or fractures that are inconsistent with injury history. The most common perpetrators are the elders’ children. “All abuse starts with caregiver stress,” says Dr. Hall. Being a caregiver can be enormously stressful; dementia caregiving can be more stressful than caring for a person with a stroke or cancer. Additionally, a caregiver with a substance abuse problem or one who is financially dependent upon the elder is more likely to be a perpetrator.

When one of Dr. Hall’s patients exhibited the classic signs of emotional abuse, she began to ask questions. Eventually the patient opened up and confided the difficulties she was having with her daughter. “I gave her some advice and she started to stand up for herself,” she says. A doctor’s appointment may be the only time that the abused elder leaves the house and is seen by a professional. Physicians and their staff need to be alert for signs and symptoms of abuse. Additionally, those suffering from self-neglect may not be shopping and cooking for themselves, and a physician may be the only one to note the weight loss and medication non-compliance. Ageism pervades healthcare as it does other areas of American society. Medical residents and physicians right out of training may be impatient with older patients, who require more time in their appointment, take many medications, and may have vague symptoms including dizziness and fatigue, which are hard to diagnose. Establishing trust is key to helping patients you suspect may be victims of abuse. They are likely to be embarrassed to admit abuse or fear retaliation. It helps to have a history with the patient and to ask questions about their lives, such as inquiring about the older man’s military service, or the older woman’s grandchildren. “If they don’t trust you, they won’t open up. Show you are interested in them as a person, not just as a patient with high blood pressure,” says Dr. Hall. Physicians can help their patients by fulfilling their responsibility as “mandatory reporters” and reporting suspected abuse to the appropriate adult protective services agency. These agencies keep all reports confidential and they can be anonymous. For abuse in the community, contact the local (county) adult protective services department or office of aging. For abuse in a nursing home, contact your state long-term care ombudsman. For abuse in an assisted-living setting contact the department of health of your state for appropriate direction.

To refer a patient to Dr. Hall for evaluation at the Geriatric Assessment Program (GAP) at Euclid Hospital, please call 216.692.8876. For more information, visit euclidhospital.org/SpecialtiesServices/GeriatricAssessmentProgramGAP
Fecal incontinence affects 15.3 percent of patients over 70, yet often goes undetected and undiagnosed. Patients are embarrassed to mention the problem and physicians may be too busy dealing with more “serious” conditions or with the management of chronic diseases such as hypertension or diabetes to ask about it. But fecal incontinence undermines quality of life as much or more than many diseases associated with aging. “Many patients report feeling like prisoners in their own homes and become depressed and isolated. It’s hard for them to go out when they leak stool: adult diapers, which are designed for urinary incontinence, don’t collect stool well,” says Brooke Gurland, MD, FACS, FASCRS, a colorectal surgeon in the Cleveland Clinic’s Digestive Disease Institute.

Fecal incontinence in the elderly has many causes: the anal sphincter muscle function weakens with age and loose watery stools and frequent bowel movements exacerbate the problem. Anal nerves or muscles are sometimes injured during childbirth and can worsen with age, which accounts for the higher incidence of fecal incontinence in younger women. Rectal prolapse, rectocele or prolapse of another pelvic organ are more common in elders and can lead to incontinence. Polypharmacy may contribute as well. An older person may tolerate an occasional drug that increases fecal urge, such as metformin (for diabetes); one of the cholinesterase inhibitors for dementia (e.g. donepezil, rivastigmine or galantamine); muscle relaxants (for pain); or even statins. Supplements and/or tube feedings increase stool looseness. Lifestyle issues such as alcohol and caffeine use may contribute to increased stooling. But when several medications are used concomitantly, fecal incontinence may ensue.

Stroke and dementia can disrupt higher cognitive functioning, which allows the brain to send signals to the lower bowel for normal motility, rectal sensation, anal muscular contraction and defecation. In late-stage Alzheimer’s disease, patients may lack the mental capacity to recognize the urge to defecate. Older people often have limited mobility, which makes it difficult to get to the bathroom in time. Chronic constipation and fecal impaction, although counterintuitive, also may be associated with fecal incontinence.
Some older people think that fecal incontinence is a normal part of aging and accept it until it becomes severe. Physicians are busy dealing with the many life-threatening diseases that afflict older people and have less and less time to discuss their overall health and well-being. “There’s a perception among physicians that there aren’t many treatment options for fecal incontinence; that it’s mainly a quality-of-life problem. They need to inquire about fecal, urinary, vaginal and sexual dysfunction, which often are related,” says Dr. Gurland.

Patients are diagnosed based on their reported symptoms and a physical examination, which may include anal manometry to assess the functioning of the internal and external anal sphincter muscles. Ultrasound or MRI can be used to further evaluate the anal and pelvic muscles. Proctography shows how much stool the rectum can hold and how well it can hold and evacuate the stool, and occult rectal prolapse. Anal electromyography tests for nerve damage, including childbirth injury. Patients who experience a change in bowel movement should have a colonoscopy to check for cancer, polyps or colitis.

The initial evaluation of the patient with fecal incontinence should be to identify polypharmacy and lifestyle problems that are amenable to intervention. After this evaluation, primary treatments are fiber and antidiarrheals to add bulk and make stools easier to control. Enemas help to clean out the bowel and prevent leakage in cases of fecal impaction. Dietary changes may be needed; foods and beverages such as chocolate, coffee and tea relax internal anal sphincter muscles. Constipation or impacted stools can be treated with fluids, fiber, laxatives and stool softeners. Dr. Gurland also recommends using probiotics to aid regularity and promote good bowel health.

When fecal incontinence is caused by a lack of anal sphincter control or decreased awareness of the urge to defecate, bowel training and physical therapy can help. Trying to have a bowel movement after eating can provide greater control and predictability over the need to use the toilet. Physical therapy and biofeedback use exercises to strengthen the anorectal muscles.

When medical therapies aren’t effective, there are other non-surgical treatments. Sacral nerve stimulation is used for urinary incontinence and has proved effective for fecal incontinence as well. It has yet to be approved for fecal incontinence by the Food and Drug Administration, but that is likely to happen soon. Patients with both types of incontinence, which is common, can benefit from having a permanent pulse generator implanted in the anus.

Procon2 is a single-use disposable balloon cuff catheter that is inserted into the rectum. The Department of Colorectal Surgery currently is running a study of the Procon2 and finding that some patients like it while others don’t want to wear a device and prefer a surgical cure. The department also is beginning a Phase 2 trial of a rectal sling.

Surgery is indicated for patients with severe fecal incontinence that seriously impacts functioning and quality of life. A sphincteroplasty repairs a damaged or weakened anal sphincter; surgery also can correct rectal prolapse and rectocele and remove hemorrhoids that prevent complete closure of the anal sphincter. An artificial anal sphincter can be used to replace a damaged anal sphincter.

When elderly patients present with fecal incontinence that does not readily respond to treatment, referral to a specialist can make a huge difference in their quality of life. “Patients need to know that there are places where they can get help. A supportive environment where patients can discuss their problems can be therapeutic,” says Dr. Gurland. Our team includes two nurse practitioners and three physicians. For patients with combined bowel and bladder or vaginal prolapse, we work closely with colleagues in urology and urogynecology to provide a multidisciplinary evaluation and treatment plan.

To refer a patient to Dr. Gurland for evaluation of fecal incontinence, please call 216.445.3604.
Medical and Surgical Options Provide Relief from Spinal Stenosis Pain

When geriatric patients complain of difficulty walking or standing, or have numbness or weakness in the legs, hips, buttocks, groin or lower back, they may be experiencing a common condition of aging: spinal stenosis. As we age, our joints get larger, ligaments thicken, the spine bulges and the nuclei of intervertebral discs become drier. Spinal stenosis usually is associated with advanced osteoarthritis, which causes bony overgrowths to protrude into the spinal column and cause narrowing around the spinal cord, most often in the lower back.

Spinal stenosis symptoms resemble other age-related conditions, such as vascular claudication and cardiovascular disease. But spinal stenosis has one defining characteristic: pain can be relieved by squatting or bending forward, positions that increase the diameter of the affected canal and “unpinch” the nerves. Edward Benzel, MD, neurosurgeon at the Cleveland Clinic Center for Spine Health, calls this response “the shopping cart sign” – since pushing a shopping cart allows the affected patient to bend forward while walking. It is highly characteristic of neurogenic claudication.

Twenty percent of people over 65 have imaging evidence of spinal canal narrowing but many are asymptomatic. Patients must have difficulty functioning to be diagnosed with the condition. Ten to 15 years ago, spinal stenosis was not properly diagnosed, according to Daniel Mazanec, MD, Associate Director of the Center for Spine Health. Today, “most spine specialists and internists are much more aware of this condition,” he says.

The diagnosis of spinal stenosis is based mainly on clinical history and symptoms, with imaging confirming spinal degeneration. In more severe cases, patients have problems controlling urine or bowel movements. A physical examination is performed mainly to exclude conditions that mimic spinal stenosis, such as osteoarthritis of the hips and peripheral arterial disease.

Treatment options have expanded in recent years. While spinal stenosis remains the most common reason for spine surgery in people over 65, surgery should be the treatment of last resort. “We are actively involved in looking for non-surgical ways to improve quality of life,” says Dr. Mazanec.

One treatment that often is underestimated, according to Dr. Mazanec, is physical therapy. Patients at the Center for Spine Health are routinely referred to physical therapy to mechanically stretch and strengthen muscles, particularly the core abdominal muscles, and relieve tightness in the legs and buttocks. The Center currently is investigating one type of PT exercise, supported walking, in which patients walk on a treadmill supported by a harness to relieve the stress of gravity.

Pain medications, from NSAIDs to opioids, are sometimes prescribed. Relief is usually transient, but pain medications may provide sufficient relief to allow the person to participate in physical therapy, which may provide a more lasting relief from symptoms. Epidural steroid injections can help reduce swelling and inflammation of the nerve roots, but relief lasts for only a few days or weeks.

Better results may be achieved with the anticonvulsant, Neurontin®, which currently is being studied with Cleveland Clinic patients. Patients who take the drug for four months experience reduced pain, increased walking distance and less sensory deficit. “In my practice, Neurontin use has significantly reduced the number of surgeries,” says Dr. Benzel. Second-generation anticonvulsants such as Lyrica® and Topamax® are being evaluated for use in spinal stenosis as well.

Overall, medical treatment is effective in about 66 percent to 75 percent of spinal stenosis patients. For patients who don’t respond to treatment, surgery is indicated when they “can’t walk a short distance without significant pain and discomfort, don’t respond well to medication management and don’t have contraindications to surgery,” reports Dr. Mazanec.
Most often, Dr. Benzel performs a laminectomy (or lumbar decompression), in which the lamina, bone spurs and damaged disks are removed to allow more room for the spinal nerves and column and restore normal blood flow to the nerves. He uses bone to fuse or stiffen the spine rather than screws and rods, which often aren’t held well by aging bones. “Surgery is very effective,” he says, “but there can be complications, such as nerve injuries or leakage. In general, once patients recover from surgery, they do very well.”

A new type of minimally invasive surgery for spinal stenosis, using a device known as an X-STOP, was approved by the FDA in 2005; since then approximately 10,000 procedures have been performed. The X-STOP is a titanium implant that is inserted into the back at the lumbar spine segment with symptomatic spinal stenosis; it prevents the patient from bending too far backward but allows forward movement. In an X-STOP procedure, only minimal removal of bone or soft tissue is needed.

“Early studies show that in selected patients with simple stenosis, X-STOP surgery is as effective as decompressing the spinal canal,” says Dr. Mazanec. Compared with traditional laminectomy, minimally invasive X-STOP procedure results in less operative blood loss, less postoperative pain, a shorter hospital stay, and lower narcotic usage. Such surgery, however, should be reserved only for those patients who would not tolerate a more definitive operation.

An MRI of a 67-year-old male with progressive difficulty with walking. He could only walk ½ block at a time. This MRI demonstrates low lumbar (low back) stenosis (narrowing) in the midline (left image). More laterally (right image), the narrowing is much more significant. Such narrowing often results in the aforementioned symptoms. Surgery (decompressive laminectomy) may be recommended to relieve these often debilitating symptoms.

To refer a patient to the Center for Spine Health, call 216.636.5860 or toll-free 866.588.2264. Patients are seen at multiple locations throughout the region.
As a society, we have yet to form a consensus on the value of cancer care — what chance of success and degree of benefit justify the expenditure of limited resources.

This ethical and philosophical debate plays out everyday at Cleveland Clinic and other cancer centers around the country. All cancer patients ask themselves whether they should choose a treatment that is costly, but could prolong their lives for an undetermined amount of time. The trade-offs can be even more challenging for elderly patients diagnosed with cancer.

Even as the field of geriatric oncology grows, its goals are not uniformly stated. Some healthcare professionals assert that treatment of elderly cancer patients should aim to maintain or augment quality of life; others emphasize identifying effective treatments for the geriatric population as the goal, implying that any divergence from the approach taken with younger cancer patients reflects rationing or age-related bias.

Anne Lederman Flamm, JD, Associate Staff in Cleveland Clinic’s Department of Bioethics, hopes to shed new light on this ethical dilemma. She is proposing a research project that involves interviewing elderly cancer patients about whether and how their age and the cost of treatment influences their decision to pursue or reject chemotherapy.

Her aim is to increase the understanding of how elderly patients think about cost and age, allowing oncologists to feel more comfortable speaking with them about these issues.

“Oncologists need to recognize the influence of cost on treatment decisions,” Ms. Flamm stresses.

**Rising population group, rising cancer rates**

The influences of age and cost considerations have yet to be thoroughly investigated, but they are important because geriatric patients tend to be on fixed incomes, and they have comorbidities concurrently requiring medical treatment and other forms of supportive care.

Ms. Flamm says her urgency to research these issues is based on U.S. Census Bureau projections that the number of people age 65 and older will double from 35 million to 70 million by 2030, comprising about 20 percent of the population. More than 5 percent of the population will be age 80 and older.

The incidence of cancer diagnosed in the elderly also is rising, she says. Concurrently, the rising costs of cancer care further heighten the need to clarify what benefit and value mean to cancer patients.

She acknowledges there are empirical studies suggesting an age bias against treating geriatric cancer patients across treatment options — including surgery, chemotherapy and radiotherapy — despite evidence they tend to do as well as younger patients when stage-appropriate therapies are administered. “Age itself is not the kicker for whether a patient will or will not do well,” notes Ms. Flamm, adding other issues, such as performance status, renal function or a combination of factors, might be better predictors of success. “Just knowing a patient is 75 is proving not to tell you much.”

Yet, there is uncertainty and a lack of best evidence as to how to treat geriatric cancer patients. Physicians often reduce the standard dosage of a cancer-fighting drug because they are worried about greater side effects or greater impact of known side effects.

Elderly patients are historically under-represented in clinical trials compared with pediatric patients and younger adults. When they are offered participation, elderly patients don’t decline at any greater rates than other groups, but they are not offered the opportunity as much. Is that bias, uncertainty, or is it legitimated in some way by outcomes? “We don’t have the empirical piece definitively answered yet,” Ms. Flamm says. “But depending on what you read, there are people who find it to be age bias.”

There is a growing movement among some geriatric oncologists to focus clinical studies directly on elderly cancer patients. Another push is for a more comprehensive geriatric assessment before designing and recommending treatment options, though Ms. Flamm points out the present state of healthcare does not lend itself to compensate in terms of time and money for an assessment that can take two hours or longer. (One of the initiatives of Taussig
Cancer Institute’s Oncology Program for Seniors is to develop a screening assessment to indicate whether a patient needs a full, comprehensive assessment.

Is it age bias?

Ms. Flamm hopes her research illuminates whether and how geriatric cancer patients factor their age into the decision-making process; for example, whether and how often patients conclude, “I would choose this treatment if I was 70, but not at 90,” — and if so, what is their reasoning. Is it because they are satisfied with having lived a full life, they don’t want to experience treatment hardships for what they see is a limited payoff, or other considerations?

Is that attitude age bias? To the most objective and dispassionate person, the answer is yes. But is it age bias if the patient makes the decision for him or herself?

These questions have implications not just for individual patient encounters, but for societal policy as well. Few find age-based limitations a comfortable proposition to redress rising cancer care costs. “Should we weigh decisions in geriatric vs. non-geriatric settings differently?” Ms. Flamm says. “I would say we could avoid it by being just as explicit and comprehensive in weighing the benefits and costs of cancer treatments at every stage of life.”
Cleveland Clinic Lerner Research Institute biomedical engineers have secured a $3 million grant from the Ohio Third Frontier program to support development of an innovative approach to rehabilitation through "Clinically Applied Rehabilitation Engineering (CARE)." The research team will work with staff from Cleveland Clinic Department of Physical Medicine & Rehabilitation of the Center for Geriatric Medicine, Case Western Reserve University, and the Advanced Platform Technology Center of Excellence at the Louis Stokes Cleveland VA Medical Center. They will pool their expertise in biomechanics, translational research and development, commercialization success, and clinical excellence to improve the understanding of mobility-related conditions and diseases, create and market state-of-the-art clinical rehabilitation devices and establish Ohio as a rehabilitation destination.

This award, approved by external review by the National Academies of Science, is part of Ohio Third Frontier’s Wright Projects Program Funding, a program that provides funds for the purchase of capital equipment to support defined commercialization goals within the technological sector. The major piece of equipment for the CARE program is a CAREN rehabilitation system by Motek Medical and Bertec Corporation that will be housed at Cleveland Clinic. The military is currently using similar equipment for the rehabilitation of wounded soldiers.

“We are now expanding on this available technology, applying it to clinical, research, and commercialization purposes,” says Margot Damaser, PhD, the lead investigator who will be carrying the project forward with Co-Principal Investigator, Jay Alberts, PhD.

The proposed CARE system is designed to target patients requiring any of a broad range of rehabilitative intervention. Among the diseases to be addressed are: cardiovascular (e.g., stroke, peripheral vascular disease), neurodegenerative (e.g. Parkinson’s disease, multiple sclerosis), metabolic (e.g. diabetes), and musculoskeletal (e.g. arthritis). In addition, this system will allow much needed research into the effects of these diseases and related conditions, such as aging and injury, on balance and mobility.

Energy-efficient gait orthoses for multiple sclerosis and spinal cord injury patients, adaptive exercise systems for Parkinson’s Disease patients, and an integrated dressing for treating pressure ulcers, are all examples of products the CARE team proposes to develop and market.

“All of these applications are possible only because of the interdisciplinary network of physicians and world-class researchers at the forefront of pursuing bench-to-bedside concepts in an environment that promotes innovation,” says Dr. Damaser. Commercialization will not only provide a completely new line of services, but also will help secure technology-based jobs in Ohio, a major goal of the Ohio Third Frontier. Until now, research and clinical application of rehabilitation devices have been severely limited by the inability of traditional technology to reliably assess a dynamic subject. This meant that reaching rehabilitation goals was often ineffective.

This has all changed with advanced technologies compiled by Motek Medical and Bertec Corporation. The system that will be used by the CARE project incorporates a “smart” platform that can move with six degrees of freedom using software to simulate everything from bomb-blasted terrain to bumps in a sidewalk. It can respond to input data in real-time so precisely that it can maintain a pencil balanced on end. Dual treadmills allow for mechanized assist to a patient’s mobility-challenged side. A virtual reality component adds a real-world touch while maintaining a safe, controlled environment, and a five-meter-wide screen provides optimal visualization. These features will allow research, clinical, and product applications that have been previously impossible.
The emergency department doesn’t tend to be a medically friendly environment for geriatric patients.

“It’s the nature of the operation,” says Fredric Hustey, MD, an emergency staff physician in Cleveland Clinic’s Emergency Medicine Department. “The emergency department is typically characterized by a need for fast-paced care and rapid decision-making. Older emergency patients tend to be more complex. In order to get really good care, they require more of a time commitment from the healthcare provider. The emergency department system is not structured in that way.”

When geriatric patients come to the emergency department, doctors not only have to treat the immediate injury or illness, but they need to be cognizant of other health issues. “You’re trying to figure out what contributed to the situation,” Dr. Hustey says. For example, caring for a young adult with an injury after a fall is much different than caring for an older patient. Falls in older patients are often the result of other underlying medical problems that need to be uncovered and addressed. The psychological context of the injury must be identified, as well. Making matters more difficult is the fact that there has been a lack of focus in geriatrics in emergency medicine training. As such, many residents and interns are apprehensive when treating geriatric patients, Dr. Hustey says.

But with a population that continues to age, emergency departments will likely see more and more geriatric patients in the years ahead. Patients 65 years and older comprise an estimated 12 percent of the trauma population, a figure that is expected to increase to an estimated 40 percent by 2050 (Campbell et al., Geriatrics 2009; 64(1). “It’s a big problem,” Dr. Hustey points out. “Unfortunately, emergency medicine isn’t quite prepared to deal with it yet.”

Dr. Hustey is a nationally recognized figure in geriatric emergency medicine. He has served as principle investigator and has published several studies on quality issues in geriatric emergency care. And he is putting that experience to work in trying to improve the quality of care of geriatric patients in emergency medicine.

Supported by a grant from the American Geriatric Society and John A. Hartford Foundation, Dr. Hustey implemented a geriatric curriculum in 2008 for emergency medicine residents. Part of the curriculum is five interactive, web-based training modules — inappropriate prescribing practices, altered mental status, geriatric trauma and elder abuse, pain management and procedural sedation, and acute abdominal pain.

The curriculum has generated immediate results, Dr. Hustey says. Residents are more interested in — and more comfortable with — treating geriatric patients. “They have a greater level of understanding of the unique features of caring for older patients.”

As a result, residents have begun to teach attendees on certain issues of geriatric care stemming from cutting-edge literature. “Residents are taking great pride in geriatric care,” he says.

Dr. Hustey is designated as an American Geriatrics Society Dennis W. Jahnigen Scholar. In this role, his research is focused on examining electronic systems for healthcare information maintenance and transfer between skilled nursing facilities and emergency departments. His research demonstrated an improvement in written communication after implementation of such a system when patients were transferred to the emergency department.

He also is a member of the Academy of Geriatric Emergency Medicine within the Society for Academic Emergency Medicine, a group dedicated to improving the care of geriatric patients.

The current level of investment being made in improving acute geriatric care in the emergency department setting is an acknowledgment that Cleveland Clinic — and the medical community at large — takes this issue seriously, Dr. Hustey stresses.

“We are way ahead of where we were 10 years ago, but we still have a long way to go,” he notes.

To learn more about Dr. Hustey’s geriatric curriculum for emergency medicine residents, contact him at 216.445.4558 or husteyf@ccf.org.
Journal Publications


Book Chapters


Grant Bolsters Geriatric Training

Cleveland Clinic geriatrician Amanda Lathia, MD, has received a grant from the Health Resources and Services Administration (HRSA) aimed at enhancing geriatric training through Cleveland Clinic Lerner College of Medicine. Dr. Lathia will receive approximately $375,000 over the next five years to broaden geriatric teaching.

The grant, part of $17 million recently awarded by HRSA, was one of just 68 in the country and the only one in greater Cleveland earmarked as Geriatric Academic Career Awards (GACA). A total of $5 million in GACA funding will support career development for academic geriatric specialists to help address the fast-growing 65-plus population, which is expected to almost double by 2030.

GACA grants focus on chronic disease management, geriatric ethics, palliative care and health promotion. Award recipients also work with underserved and uninsured patients across many community settings including acute, ambulatory and long-term care.
Geriatric Medicine Staff

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All physicians with appointments in Regional Geriatrics have a joint appointment in the Center for Geriatric Medicine

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24/7 hospital transfers or physician consults
800.553.5056

Internal Medicine and Geriatric Medicine Appointments/Referrals
216.444.5665 or 800.223.2273, ext. 45665
On the Web at clevelandclinic.org/geriatrics

Physician Directory View all Cleveland Clinic staff online at clevelandclinic.org/staff.

Referring Physician Center For help with service-related issues, information about our clinical specialists and services, details about CME opportunities and more, contact us at refdr@ccf.org, or 216.448.0900 or toll-free 888.637.0568.

Critical Care Transport Worldwide Cleveland Clinic’s critical care transport team and fleet of mobile ICU vehicles, helicopters and fixed-wing aircraft serve critically ill and highly complex patients across the globe.

To arrange a transfer for STEMI (ST elevated myocardial infarction), acute stroke, ICH (intracerebral hemorrhage), SAH (subarachnoid hemorrhage) or aortic syndromes, call 877.379.CODE (2633). For all other critical care transfers, call 216.444.8302 or 800.553.5056.

Track Your Patient’s Care Online DrConnect offers secure access to your patient’s treatment progress at Cleveland Clinic. To establish a DrConnect account, visit clevelandclinic.org/drconnect or email drconnect@ccf.org.

Remote Consults Request a remote medical second opinion from a Cleveland Clinic geriatrician. Visit clevelandclinic.org/geriatrics-secondopinion

Stay Connected to Cleveland Clinic
New Center for Geriatric Medicine Opens

Cleveland Clinic’s new Center for Geriatric Medicine has moved into expanded and renovated space at 10685 Carnegie Avenue on main campus. The 11,000-square-foot building is notable for its accessibility, with close-in patient parking in the front and a check-in desk near the outside door. Elders with or without mobility difficulties are accommodated with side hallways, accessible restrooms and large examination rooms that have space for the patient and up to two family members. A quite consultation room offers privacy for patient and family counseling and education. The first floor includes 12 exam rooms, an on-site laboratory, a Coumadin Clinic and a library.

The renovated space allows older adults referred for geriatric assessments to be seen by a nurse and physician trained in geriatric problems on site. Consultations with social services and a geriatric pharmacist can be coordinated on an as-needed basis during the same visit. Several additional specialists, including cardiologists, gynecologists, urologists, neurologists, neurosurgeons and orthopaedists focus on problems that are prevalent in older patients and offer services at the center on a part-time basis. Therapists who specialize in cognition, swallowing disorders, incontinence, osteoporosis, balance and other issues common in the elderly, also support the center.

The Center for Geriatric Medicine is both a location for care and a center for leadership. The center serves as an umbrella for geriatric learning, research and clinical activities throughout the Cleveland Clinic health system, offering guidance with geriatric activities including protocols for falls and delirium. Dementia care is another significant component of the center’s clinical, teaching and research efforts.

The geriatric staff also has expanded and now offers multi-specialty clinics and outreach programs at Cleveland Clinic Health System hospitals and family health centers throughout Northeast Ohio.

To schedule an appointment or to refer a patient to the Center for Geriatric Medicine, please call 216.444.5665.